SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF HUMAN SERVICES BILL)

A BILL FOR

An Act relating to programs and activities under the purview of the department of human services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

S.F. _____ H.F. _____

DIVISION I

HEALTHY AND WELL KIDS IN IOWA —— DIRECTOR DUTIES

Section 1. Section 514I.4, subsection 5, Code 2018, is amended by adding the following new paragraphs:

NEW PARAGRAPH. *d.* Collect and track monthly family premiums to assure that payments are current.

NEW PARAGRAPH. *e.* Verify the number of program enrollees with each participating insurer for determination of the amount of premiums to be paid to each participating insurer.

Sec. 2. Section 514I.7, subsection 2, paragraphs g and i, Code 2018, are amended by striking the paragraphs.

DIVISION II

SHARING OF INCARCERATION DATA

Sec. 3. Section 249A.38, Code 2018, is amended to read as follows:

249A.38 Inmates of public institutions —— suspension or termination of medical assistance.

1. The ~~following conditions shall apply to~~ department shall suspend the eligibility of an individual who is an inmate of a public institution as defined in 42 C.F.R. §435.1010, who is enrolled in the medical assistance program at the time of commitment to the public institution, and who remains eligible for medical assistance as an individual except for the individual's institutional status~~:~~

~~*a.* The department shall suspend the individual's eligibility for up to the initial twelve months of the period of commitment. The department shall delay the suspension of eligibility for a period of up to the first thirty days of commitment if such delay is approved by the centers for Medicare and Medicaid services of the United States department of health and human services. If such delay is not approved, the department shall suspend eligibility during the entirety of the initial twelve months of the period of commitment. Claims submitted on behalf of the individual under the medical assistance program for covered services provided during the~~

~~delay period shall only be reimbursed if federal financial participation is applicable to such claims.~~

~~*b.* The department shall terminate an individual's eligibility following a twelve-month period of suspension of the individual's eligibility under paragraph "*a*"~~, during the period of the individual's commitment to the public institution.

2. *a.* A public institution shall provide the department and the social security administration with a monthly report of the individuals who are committed to the public institution and of the individuals who are discharged from the public institution. The monthly report to the department shall include the date of commitment or the date of discharge, as applicable, of each individual committed to or discharged from the public institution during the reporting period. The monthly report shall be made through the reporting system created by the department for public, nonmedical institutions to report inmate populations. Any medical assistance expenditures, including but not limited to monthly managed care capitation payments, provided on behalf of an individual who is an inmate of a public institution but is not reported to the department in accordance with this subsection, shall be the financial responsibility of the respective public institution.

b. The department shall provide a public institution with the forms necessary to be used by the individual in expediting restoration of the individual's medical assistance benefits upon discharge from the public institution.

~~3. This section applies to individuals as specified in subsection 1 on or after January 1, 2012.~~

~~4.~~ 3. The department may adopt rules pursuant to chapter 17A to implement this section.

DIVISION III

REPORTS —— MEDICAL ASSISTANCE DRUG UTILIZATION REVIEW AND MEDICAID MANAGED CARE OVERSIGHT

Sec. 4. Section 249A.24, subsection 4, Code 2018, is amended

by striking the subsection.

Sec. 5. 2016 Iowa Acts, chapter 1139, section 93, is amended to read as follows:

SEC. 93. DEPARTMENT OF HUMAN SERVICES —— REPORTS. The department of human services shall submit to the chairpersons and ranking members of the human resources committees of the senate and the house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services~~, quarterly reports, and~~ an annual report ~~beginning December 15, 2016, and annually~~ by December ~~15, thereafter~~ 31, regarding Medicaid program consumer protections, outcome achievement, and program integrity as specified in this division. The reports shall be based on and updated to include the most recent information available. The reports shall include an executive summary of the information and data compiled, an analysis of the information and data, and any trends or issues identified through such analysis, to the extent such information is not otherwise considered confidential or protected information pursuant to federal or state law. The joint appropriations subcommittee on health and human services shall dedicate a meeting of the subcommittee during the subsequent session of the general assembly to review the annual report.

1. CONSUMER PROTECTION.

The general assembly recognizes the need for ongoing review of Medicaid member engagement with and feedback regarding Medicaid managed care. The Iowa high quality health care initiative shall ensure access to medically necessary services and shall ensure that Medicaid members are fully engaged in their own health care in order to achieve overall positive health outcomes. The consumer protection component of the reports submitted as required under this section shall be based on all of the following reports relating to member and provider services:

a. Member enrollment and disenrollment.

b. Member grievances and appeals including all of the following:

(1) The percentage of grievances and appeals ~~resolved~~ adjudicated timely.

(2) The number of grievances and appeals received.

c. Member call center performance including the service level for members, providers, and pharmacy.

d. Prior authorization denials and modifications including all of the following:

(1) The percentage of prior authorizations approved, denied, and modified.

(2) The percentage of prior authorizations processed within required timeframes.

e. Provider network access including key gaps in provider coverage based on contract time~~,~~ and distance standards~~, and market share~~.

f. Care coordination and case management, including the ratio of members to care coordinators or case managers~~, and the average number of contacts made with members per reporting period~~.

g. Level of care and functional assessments, including the percentage of level of care assessments completed timely.

~~h. Population-specific reporting including all of the following:~~

~~(1) General population, including adults and children.~~

~~(2) Special needs, including adults and children.~~

~~(3) Behavioral health, including adults and children.~~

~~(4) Elderly.~~

i. (1) Number of individuals served on the home and community-based services (HCBS) waivers by waiver type, and HCBS waiver waiting list reductions or increases.

(2) Number of individuals enrolled in 1915(i) HCBS habilitation services.

2. OUTCOME ACHIEVEMENT.

The primary focus of the general assembly in moving to

Medicaid managed care is to improve the quality of care and outcomes for Medicaid members. The state has demonstrated how preventive services and the coordination of care for all of a Medicaid member's treatment significantly improve the health and well-being of the state's most vulnerable citizens. In order to ensure continued improvement, ongoing review of member outcomes as well as of the process that supports a strong provider network is necessary. The outcome achievement component of the reports submitted as required under this section shall be based on all of the following reports:

a. Contract management including all of the following:

(1) Claims processing including all of the following:

(a) The percentage of claims paid, denied, and disputed, and the ten most common reasons for claims denials.

(b) The percentage of claims adjudicated timely.

~~(2) Encounter data including all of the following:~~

~~(a) Timeliness.~~

~~(b) Completeness.~~

~~(c) Accuracy.~~

(3) Value-based purchasing (VBP) enrollment including the percentage of members covered by a VBP arrangement.

(4) Financial information including all of the following:

(a) Managed care organization capitation payments.

(b) The medical loss ratio, administrative loss ratio, and underwriting ratio.

~~(c) Program cost savings.~~

~~(5) Utilization of health care services by diagnostic related group and ambulatory payment classification as well as total claims volume.~~

(6) Utilization of value-added services.

(7) Payment of claims by department-identified ~~provider~~ service type.

(8) Utilization of 1915(b)(3) services that are being provided in lieu of state plan services, including institutions for mental disease services.

b. Member health outcomes including all of the following:

(1) Annual health care effectiveness and information set (HEDIS) performance.

~~(2) Other quality measures including all of the following:~~

~~(a) Behavioral health.~~

~~(b) Children's health outcomes.~~

~~(c) Prenatal and birth outcomes.~~

~~(d) Chronic condition management.~~

~~(e) Adult preventative care.~~

~~(3) Value index score (VIS) performance.~~

~~(4) Annual consumer assessment of health care providers and systems (CAHPS) performance.~~

(5) ~~Utilization~~ Annual utilization information including all of the following:

(a) Inpatient hospital admissions and potential preventative admissions.

(b) Readmissions.

(c) Outpatient visits.

(d) Emergency department visits and potentially preventable emergency department visits.

c. ~~Consumer~~ Annual consumer satisfaction survey results.

3. PROGRAM INTEGRITY.

a. The Medicaid program has traditionally included comprehensive oversight and program integrity controls. Under Medicaid managed care, federal, state, and contractual safeguards will continue to be incorporated to prevent, detect, and eliminate provider fraud, waste, and abuse to maintain a sustainable Medicaid program. The program integrity component of the reports submitted as required under this section shall ~~be based on all of the following reports relating to program integrity:~~

~~(1) The~~ include the reporting of the level of fraud, waste, and abuse identified by the managed care organizations.

~~(2) Managed care organization adherence to the program integrity plan, including identification of program~~

~~overpayments.~~

~~(3) Notification of the state by the managed care organizations regarding fraud, waste, and abuse.~~

~~(4) The impact of program activities on capitation payments.~~

~~(5) Enrollment and payment information including all of the following:~~

~~(a) Eligibility.~~

~~(b) Third-party liability.~~

~~(6) Managed care organization reserves compared to minimum reserves required by the insurance division of the department of commerce.~~

~~(7) A summary report by the insurance division of the department of commerce including information relating to health maintenance organization licensure, the annual independent audit, insurance division reporting, and reinsurance.~~

b. The ~~results of any~~ external quality review organization ~~review~~ annual technical report shall be ~~submitted directly to the governor, the general assembly, and the health policy oversight committee created in section 2.45~~ posted publicly to the department's website.

~~c. The department of human services shall require each Medicaid managed care organization to authorize the national committee for quality assurance (NCQA) to submit directly to the governor, the general assembly, and the health policy oversight committee created in section 2.45, the evaluation report upon which the Medicaid managed care organization's NCQA accreditation was granted, and any subsequent evaluations of the Medicaid managed care organization.~~

4. INCLUSION OF INFORMATION FROM OTHER OVERSIGHT ENTITIES.

The council on human services, the medical assistance advisory council, the hawk-i board, the mental health and disability services commission, and the office of long-term care ombudsman shall regularly review Medicaid managed care as it relates to the entity's respective statutory duties.

These entities shall submit executive summaries of pertinent information regarding their deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15, annually, for inclusion in the annual report submitted as required under this section.

5. PUBLIC POSTING OF INFORMATION REPORTED.

The department of human services shall post all of the reports specified under this section, as the information becomes available and to the extent such information is not otherwise considered confidential or protected information pursuant to federal or state law, on the Iowa health link internet site.

Sec. 6. 2016 Iowa Acts, chapter 1139, sections 95 and 96, are amended by striking the sections.

DIVISION IV

IOWA HEALTH AND WELLNESS PLAN REPORT ELIMINATION

Sec. 7. Section 249N.8, Code 2018, is amended to read as follows:

249N.8 Mental health services reports.

The department shall submit ~~all of the following~~ to the governor and the general assembly~~:~~

~~1. Biennially~~, biennially, a report of the results of a review, by county and region, of mental health services previously funded through taxes levied by counties pursuant to section 331.424A, that are funded during the reporting period under the Iowa health and wellness plan.

~~2. Annually, a report of the results of a review of the outcomes and effectiveness of mental health services provided under the Iowa health and wellness plan.~~

DIVISION V

MEDICAID PROGRAM PHARMACY COPAYMENT

Sec. 8. 2005 Iowa Acts, chapter 167, section 42, is amended to read as follows:

SEC. 42. COPAYMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAL ASSISTANCE PROGRAM. The department of human services

shall require recipients of medical assistance to pay ~~the following copayments~~ a copayment of $1 on each prescription filled for a covered prescription drug, including each refill of such prescription~~, as follows:~~

~~1. A copayment of $1 on each prescription filled for each covered nonpreferred generic prescription drug.~~

~~2. A copayment of $1 for each covered preferred brand-name or generic prescription drug.~~

~~3. A copayment of $1 for each covered nonpreferred brand-name prescription drug for which the cost to the state is up to and including $25.~~

~~4. A copayment of $2 for each covered nonpreferred brand-name prescription drug for which the cost to the state is more than $25 and up to and including $50.~~

~~5. A copayment of $3 for each covered nonpreferred brand-name prescription drug for which the cost to the state is more than $50~~.

DIVISION VI

MEDICAL ASSISTANCE ADVISORY COUNCIL

Sec. 9. Section 249A.4B, subsection 2, paragraph a, subparagraph (17), Code 2018, is amended to read as follows:

(17) The Iowa primary care association ~~of rural health clinics~~.

Sec. 10. Section 249A.4B, subsection 2, paragraph a, subparagraphs (27) and (28), Code 2018, are amended by striking the subparagraphs.

Sec. 11. Section 249A.4B, subsection 4, paragraph c, Code 2018, is amended to read as follows:

c. Based upon the deliberations of the council and the executive committee, the executive committee shall make recommendations to the director regarding the ~~budget,~~ policy~~,~~ and administration of the medical assistance program.

Sec. 12. Section 249A.4B, subsection 7, Code 2018, is amended to read as follows:

7. The director shall consider the recommendations offered

by the council and the executive committee in the director's ~~preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3 and in~~ implementation of medical assistance program policies.

DIVISION VII

TARGETED CASE MANAGEMENT AND INPATIENT PSYCHIATRIC SERVICES REIMBURSEMENT

Sec. 13. Section 249A.31, Code 2018, is amended to read as follows:

249A.31 Cost-based reimbursement.

1. ~~Providers of individual case management services for persons with an intellectual disability, a developmental disability, or chronic mental illness shall receive cost-based reimbursement for one hundred percent of the reasonable costs for the provision of the services in accordance with standards adopted by the mental health and disability services commission pursuant to section 225C.6.~~ Effective July 1, 2018, targeted case management services shall be reimbursed based on a statewide fee schedule amount developed by rule of the department pursuant to chapter 17A.

2. Effective July 1, ~~2010~~ 2014, ~~the department shall apply a cost-based reimbursement methodology for reimbursement of psychiatric medical institution for children~~ providers of inpatient psychiatric services for individuals under twenty-one years of age shall be reimbursed as follows:

a. For non-state-owned providers, services shall be reimbursed according to a fee schedule without reconciliation.

b. For state-owned providers, services shall be reimbursed at one hundred percent of the actual and allowable cost of providing the service.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to programs and activities under the purview of the department of human services (DHS). The bill is

organized into divisions.

Division I of the bill relates to the healthy and well kids in Iowa (hawk-i) program by transferring two duties of the administrative contractor, the capitation process and member premium collection, to DHS through the Iowa Medicaid enterprise.

Division II of the bill requires public institutions to provide a monthly report of the individuals who are committed to the public institution and of the individuals who are discharged from the public institution to DHS and to the social security administration. The report to DHS is required to include the date of commitment or discharge, as applicable, of each individual committed to or discharged from the public institution during the reporting period, and the report is to be made through the reporting system created by DHS for public, nonmedical institutions to report inmate populations. Any medical assistance expenditures, including but not limited to monthly managed care capitation payments, provided on behalf of an individual who is an inmate of a public institution but is not reported as required, shall be the financial responsibility of the respective public institution.

Division III of the bill relates to reports relating to the medical assistance drug utilization review commission and Medicaid managed care oversight.

The division eliminates the requirement that the medical assistance drug utilization review commission submit an annual review, including facts and findings, of the drugs on the department's prior authorization list, to DHS and to the members of the general assembly's joint appropriations subcommittee on health and human services.

The division also amends provisions in 2016 Iowa Acts relating to Medicaid managed care oversight, by eliminating the requirement for quarterly reports and only requiring an annual report to be submitted by December 31, regarding Medicaid program consumer protections, outcome achievement, and

program integrity. The bill also eliminates the reporting of certain data elements relative to consumer protections, outcome achievement, and program integrity, but adds data elements relating to the number of individuals enrolled in 1915(i) HCBS habilitation services and the utilization of 1915(b)(3) services being provided in lieu of state plan services.

The division strikes the sections in the 2016 Iowa Acts relating to program policy improvements and single-case agreements, resulting in the elimination of program policy improvements relating to the recovery of costs of services furnished to a recipient while an appeal is pending, authorization of a provider to appeal on a recipient's behalf if the recipient designates the provider as the recipient's representative, the specification of those professionals to be included as primary care providers, the prohibition against more restrictive scope of practice requirements or standards of practice for primary care providers than those prescribed by state law, and managed care organization single-case agreements with out-of-network providers.

Division IV of the bill eliminates the requirement that DHS submit to the governor and the general assembly, annually, a report of the results of a review of the outcomes and effectiveness of mental health services provided under the Iowa health and wellness plan.

Division V of the bill eliminates the various copayments for a covered prescription drug under the Medicaid program based upon the prescription drug's status, and instead provides that a recipient of Medicaid is required to pay a copayment of $1 on each prescription filled for a covered prescription drug, including each refill of such prescription.

Division VI of the bill relates to the medical assistance advisory council (MAAC). The division amends the membership of the MAAC by replacing representation by the Iowa association of rural health clinics with representation by the Iowa primary care association, and by eliminating representation by the Iowa

coalition of home and community-based services for seniors and the Iowa adult day services association. The division also eliminates the duty of the MAAC executive council to make recommendations to the director of human services regarding the budget of the Medicaid program and also eliminates the corresponding requirement that the director of human services consider the recommendations relating to the budget in the director's preparation of Medicaid budget recommendations to the council on human services.

Division VII of the bill amends the reimbursement provision for targeted case management under the Medicaid program which is currently established as cost-based reimbursement for 100 percent of the reasonable costs for provision of the services. Under the bill, effective July 1, 2018, targeted case management will instead be reimbursed based on a statewide fee schedule amount developed by rule of the department in accordance with Code chapter 17A.

The bill also amends the reimbursement for psychiatric medical institutions for children to provide that inpatient psychiatric services for individuals under 21 years of age that are provided by non-state-owned providers shall be reimbursed according to a fee schedule without reconciliation and for state-owned providers, shall be reimbursed at 100 percent of the actual and allowable cost of providing the service.